They're doing what?!

Pharmacists defend pill service against national backlash analysis page 10

London scheme shows patient benefits amid Isle of Wight furore page 4

Diprobase Prescribing Information

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"IT'S NOT CLEAR WHETHER THEIR CONDEMNATION WAS DIRECTED AT YOUNG PEOPLE HAVING SEX OR AT PHARMACISTS FOR SUPPLYING THE PILL"

Underage sex, illegal immigrants and drunken louts – it seems the country has gone to the dogs, at least according to some of the headlines in the national press.

Last week it was the turn of pharmacy as the fourth estate vented its anger at the supply of the contraceptive pill to teenagers as young as 13.

It's not clear whether their condemnation was directed at young people having sex or at pharmacists for supplying the pill. Either way it's immaterial as both the service users and providers get tarred by the same brush.

But is this national uproar and disapproval a fair response?

If the scheme was restricted to those above the legal age of consent, I'd wager there wouldn't be such a fuss. So the issue is obviously around the small group of women who fall below the minimum age of consent and the fact that the service is being provided by pharmacists and not GPs.

Let's take the first point. The facts are that Britain has the highest teenage pregnancy rates in Europe. In 2008, 60 out of every 1,000 women aged 15 to 19 in England and Wales fell pregnant. For 13 to 15-year-olds, the number falls to just under eight out of 1,000. What this information tells us is that the current system of supply via your GP simply does not address the needs of all women.

And the law is explicit about young people and their right to confidentiality. The House of Lords ruled in the Gillick case in 1985 that girls under the age of 16 have the legal capacity to consent to treatment if they have sufficient maturity to comprehend the nature and implications of the treatment.

And now to the second point of contention: should pharmacists be supplying the contraceptive pill? Looking at the results of the year-long pilot run across Southwark and Lambeth PCTs, the answer is an emphatic yes: 40 per cent of women receiving the pill in pharmacy were first-time users, and a quarter of consultations were with women under 19. The pilot has also had positive feedback from users, helped hard-to-reach ethnic groups as well as helping to cut EHC requests (p4).

There can be no question about pharmacists' ability to deliver such services. And the NHS agrees – the Welsh government is about to launch a pharmacy directed enhanced sexual health service (p6).

We should applaud the pharmacists who are pioneering these services – change is never easy and elements of society will always be vocal in their dissent if they feel the country's moral fibre is under threat. But we shouldn't let that stop genuine progress.

Gary Paragpuri, Editor

Pill pilot brings drop in EHC use

Southwark and Lambeth scheme shows benefits and helps 'hard to reach' patients

Hannah Flynn
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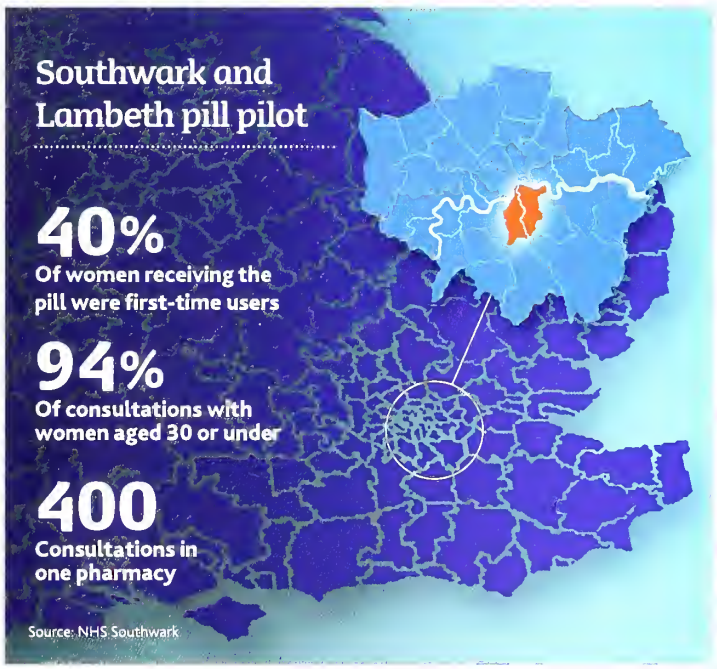

A pharmacy-led contraceptive pill pilot has received positive feedback from patients throughout and seen a noticeable reduction in the number of EHC requests in one of the two pharmacies taking part.

Southwark and Lambeth PCTs ran a joint pilot for a year up to October 2010 and found 40 per cent of women who received the contraceptive pill from their pharmacy were first-time pill users.

And the pilot had helped "hard to reach groups" from ethnic minorities, NHS Southwark said.

The news came as a similar scheme on the Isle of Wight received criticism in the national press and the results have prompted Southwark PCT to roll out the service to three more pharmacies next year.

The contraceptive pill consultations were offered to women after they presented at the pharmacy requesting EHC or the pill. Pharmacists provided 18 types of pill (progesterone-only pill and combined oral contraception) to women over 16.

According to NHS Southwark, 94 per cent of consultations were with service users aged 30 and under, 68 per cent with under 25s and 25 per cent with women aged 19 and under.

A spokesperson for the PCT said: "It is important to point out that the contraceptive pill was offered to women who are already sexually active. We want to give them a more sustainable option for women who are coming in frequently. Pharmacists also provide information about long-active contraception like implants."

Pharmacist Cuthbert Chirinda, who offered the pilot at Ridgeway Pharmacy in Lambeth, said he thinks the pilot has been a success. He added: "I think we have had a lot of improvement and the patients were excited about it. We have done 400 consultations and people like the fact that they didn't have to book an appointment."

The PCT added that it is currently supporting other PCTs in London to develop similar programmes, including City and Hackney and Croydon.

Health minister backs pill provision

Health minister Anne Milton has backed the provision of free contraception for all, including young people.

The comments came in response to a written question in Parliament, asking if the provision of free contraception had any effect on the rates of sexually transmitted diseases.

Ms Milton said in her statement that there was no evidence of a direct link between the availability of free contraception and STIs. She emphasised that contraception was available to patients under 16 if the patient understood the treatment and its implications.

Ms Milton said: "Contraception is available in the community... and we are keen to encourage its widespread use, including by young people where this is appropriate."

Pharmacists defend pill scheme against backlash
Analysis on page 10

Lansley: IT reform will save pharmacy money

The NHS 'information revolution' will mean cost savings for pharmacy, health secretary Andrew Lansley has told C+D.

Asked how much the changes would cost community pharmacists, Mr Lansley said delivering good quality information would "actually make a cost saving".

He pointed to the savings made by website NHS Choices in reducing GP call-outs and appointments, and stressed the need to use pharmacists "much more".

Mr Lansley continued in his answer: "We expect it to be cost effective. And we expect more people to visit pharmacists as foot-fall is important for them."

Mr Lansley was speaking in a web chat organised by the Department of Health. He was adamant that the benefits of the 'information revolution' as outlined in the health white paper would lead to cost savings.

And he outlined how changes to the way information is handled by the NHS will contribute to the development of meaningful outcome data. He said: "We are focusing on outcomes, processes that are more evidence based. We are getting the data at the time patients are being looked after. We reduce costs because we only need to get the data once, not repeatedly. This also saves everyone time." **HF**

Devon LPC visits Westminster

MPs have pledged to support Devon LPC in helping to get community pharmacy's voice heard. The pledge came as the LPC met with five local MPs, from all parties, at Portcullis House in Westminster to discuss pharmacy services and the NHS white paper.

Devon LPC pharmacist Mark Stone said: "It was a fantastic day. There are very good advocates for pharmacy in our local MPs. We engaged with local MPs so that they can engage with others."

Mr Stone said the MPs had offered communication links to the Health Select Committee and ministers by promoting briefing letters the LPC was putting together.

He continued that the aims of the meeting had been to make the MPs aware of pharmacy and the benefits it provides; to make sure pharmacy got representation on GP consortia boards; and to gain involvement in new NHS pathways, reducing costs and improving patient care. **MR**

Almost 900 quit Royal Pharmaceutical Society

Members request refunds after RPSGB loses regulatory powers

Zoe Smeaton
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Nearly 900 people have cancelled their membership of the Royal Pharmaceutical Society since the Society gave up its regulatory powers to become a professional leadership body in September 2010.

Members wanting a refund when the GPhC took over responsibility for pharmacy regulation had to return a refund request form to the RPS.

The Society said 871 people had asked for a refund and cancelled their membership, adding that this represented just 1.7 per cent of the RPS total membership.

A refund was given for the remaining three months of 2010 and covered the professional body element of the fee they had paid. This refund was £47 for full practising pharmacists, £18 for non-practising pharmacists, £32 for overseas pharmacists and £31 for those on low income.

Pharmacists contacted by C+D expressed mixed views on the Society. Some, including former RPSGB president Hemant Patel, said those leaving the Society had not given it enough of a chance to impress. But others said they expected more pharmacists would leave the RPS in January when their current membership expired.

An RPS spokesperson said: "We want every pharmacist to feel their Society has something to offer them – the organisation has been built around the needs of members."

They added: "We would encourage all pharmacists to explore our website or give us a call on 0845 257 2570 to find out what the new organisation is all about."

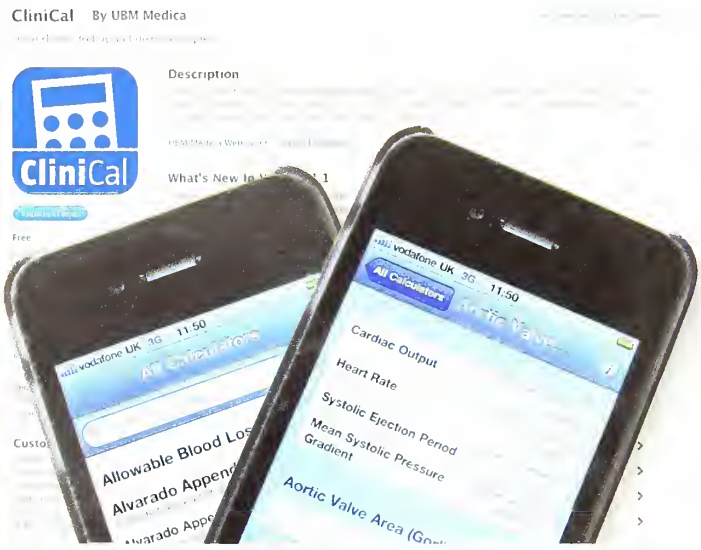
The RPS is urging members to find out what the new organisation can offer

Your views

"Although this is the inevitable consequence of people's strong feelings about the regulator, I had hoped people would give the new Society a fair chance. I can understand why people have left but it seems unfair and short-sighted."
Hemant Patel, former RPSGB president

"I think some people won't sign up again now membership isn't mandatory. People will think more about what they're going to get for their money."
Prakash Mahtani, Warwick Pharmacy, Victoria

"I think those leaving have been too quick and haven't given the RPS a chance to prove that it has changed its spots [since becoming the new professional leadership body]. It does seem more user-friendly to me [now]."
George Romanes, Romanes Pharmacy, Dunns



C+D has launched a free medical calculator for iPhones to help pharmacists make quick, accurate decisions on a patient's health. The CliniCal app includes more than 130 calculations for treatment and diagnosis, including BMI and body surface area, CVD risk, LDL cholesterol, blood glucose, predicted peak flow and creatinine clearance. Also included are dosing information for iv delivery and opioid conversion and calculations for serum phenytoin levels. The app also delivers clear advice to help interpret results. For more information or a free download of the app, go to www.chemistanddruggist.co.uk, or search for CliniCal on iTunes

DH: medicines export will not be banned

The government will not bring forward proposals to prevent the export of medicinal products in short supply, health minister Paul Burstow has said.

The announcement follows pressure to regulate the export of medicines, which manufacturers say is worsening supply chain problems and stock shortages.

In response to a written Parliamentary question, Mr Burstow said: "The government will not take forward proposals to prevent the export of any medicinal products."

He added: "The free movement of goods, including medicines, between member states of the EU is a fundamental principle of the single market upon which the EU is built, and therefore legislation to this end would be inappropriate."

Mr Burstow said the DH, MHRA and supply chain stakeholders continued to work collaboratively to better understand and mitigate the impact of supply difficulties. He added that ministers had heard from supply chain organisations as well as health professionals and patients on the issue of medicine supply.

The initial question by Bob Russell MP asked if the health minister would bring forward proposals to prevent the export of medicinal products that are in short supply in the UK in the upcoming health bill. HF

Read more [illegible] and C+D's [illegible] survey
www.chemistanddruggist.co.uk/stocksurvey2010

Dispensary talk

Would you like to be able to offer the contraceptive pill to patients presenting for EHC?

"Yes, especially to young people who won't go to GPs. We can talk to them in a good environment about the long-term benefits of the contraceptive pill."
Jignesh Patel, Rohpharm Pharmacy, Plaistow

"Absolutely, and I will be providing the service in a couple of months. It is an extension of the morning-after pill service and an addition to our roles, as well as another access point for our patients."
Raj Radia, Spring Pharmacy, London

Web verdict

Yes, it would help me offer a complete service
60%

Not sure, I'd want more details
19%

No, I'd be nervous about it
0%

No, I don't think pharmacy should offer it
21%

Armchair view: It's a good review for the contraceptive pill as more than half of C+D readers would like to embrace their clinical roles and offer it to patients. Only a fifth think the pill isn't for pharmacy, with the rest undecided.
Next week's question: Will you be joining the Royal Pharmaceutical Society next year? Vote at www.chemistanddruggist.co.uk

New service for Wales

Directed enhanced service on EHC and sexual health advice expected

Zoe Smeaton
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A pharmacy directed enhanced service around sexual health was expected to be announced in Wales as C+D went to press this week.

It would be the first such directed service for community pharmacy and would mean all health boards in Wales would be able to commission the service. Health minister Edwina Hart is expected to announce the service and to reveal that it will be available from April 2011. The service was also mentioned in a Welsh Assembly Government plan to tackle sexual health, which said work on developing a national template for the service had been taken on by the pharmacy strategic delivery group.

The report added: "The group is currently developing proposals on community pharmacy directed enhanced services... including an emergency contraception service and provision of sexual health advice."

A template patient group direction has been drafted and both elements are being consulted on, "with aim to have these in place from autumn 2010", the report said.

Chris Martin, chair of the strategic delivery group, told C+D that once announced, it would be "up to pharmacists to come forward and offer support" for the service.

Mr Martin said the move recognised the work pharmacy had already done on sexual health and that it would be good to have such an important service available throughout Wales. He added that progress on three other directed enhanced services the group had been working towards was "struggling", but work was ongoing.

Painkiller risk in pregnancy found

Taking more than one mild analgesic during pregnancy may increase the risk of giving birth to a son with cryptorchidism a study has found.

The study, published in Human Reproduction, found women taking more than one OTC painkiller simultaneously at any time during pregnancy had a seven-fold increased risk of cryptorchidism.

Use of any analgesic in the second trimester doubled the risk, although this was only statistically significant in women who used ibuprofen or aspirin, not paracetamol. Using more than one painkiller during the second trimester resulted in a 16-fold increased risk.

Cryptorchidism is a risk factor for poor semen quality in later life. **CC**

Read the clinical analysis at www.chemistanddruggist.co.uk/news

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

Forget homeopathy – try yoghurt

There's a common misconception that believing in evidence-based medicine means you're instinctively opposed to any treatment that doesn't come from a blister pack.

In the past week, two major surprises have sprung up in the world of non-drug therapy, one of which should help shake that view to pieces.

First up, the Royal Pharmaceutical Society denounced homeopathy as "clearly not" medicine. The treatment had no evidence base, the RPS continued, and should only ever be used for minor, self-limiting conditions.

The condemnation didn't stop there. According to chief scientific officer Jayne Lawrence: "Advertising for any homeopathic product... needs to include the statements that there is no scientific evidence for homeopathy nor any evidence to support the clinical efficacy of homeopathic products beyond a placebo effect."

In terms of evidence-based medicine, it's a move to be welcomed, albeit one sure to draw fire from practitioners who insist the evidence is there.

But, unfortunately for any potential protesters, a perfect counter to claims of ignored evidence emerged on Wednesday from the Cochrane Collaboration: a meta-analysis has found probiotics can help treat diarrhoea.

Previously, there has been a paucity of evidence probiotics work for this indication, leading to a healthy dose of scepticism (albeit not in the same league as for the scientifically implausible homeopathy) over their use.

But the Cochrane analysis, which included 63 trials and 8,014 patients, found probiotics (when used with rehydration fluids) reduced the duration of diarrhoeal bouts by around a day, and cut the risk of diarrhoea lasting four or more days by 59 per cent. Better yet, only one, mild, adverse effect was reported.

This is promising news, especially for parents (56 of the trials focused on children). And it's a coup for evidence-based medicine too: proof that ideas beyond the blister pack aren't dismissed out of hand.

It looks like it's time to clear homeopathic products from the shelves, and start stocking up on yoghurts instead.

Chat with Chris on Twitter: www.twitter.com/CandDChris

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GB.SAA.10.07.01 Date of preparation: June 2010

In brief

Meningitis vaccination

Twenty pharmacies across Scotland and England have started to offer meningitis vaccinations to patients attending the Hajj pilgrimage in November, supported by Novartis Vaccines & Diagnostics and AAH.

Chronic conditions

Measures designed to improve care for people with chronic conditions, including some pharmacy schemes, have been deemed a success by NHS Wales. There has been a 10.8 per cent reduction in the number of emergency medical admissions from chronic conditions in the pilot areas.

250,000 online repeats

Website-based repeat prescription service myrepeats.com has announced it has received orders for a quarter of a million items. The website allows patients to submit their repeat requests online and then have the items delivered.

Starting point

If the DH wants to give patients greater choice over their health and wellbeing, it should start by making a wider ranger of primary healthcare services available at pharmacies, AAH has said in its response to the DH consultation on patient choice and control.

Web solution

UK healthcare marketing company Orangetonic is set to launch a clinical services website solution that will enable patients to order repeat prescriptions online, book clinical services and order products for home delivery from independent pharmacies.

Safety workshops

Numark is set to pilot free personal safety workshops for members. They are being offered in recognition of the safety risks associated with being an independent pharmacist and the lack of NHS support in this area, according to the group.

Virtual pharmacist tool launches in Birmingham

Animated 'Mr Pharm' offers touch-screen health advice in pharmacies

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Pharmacies across Birmingham have launched a 'virtual pharmacist' system to help give patients advice on medicines and conditions.

The Mr Pharm initiative has seen touch-screen computers installed in 67 pharmacies across Heart of Birmingham Teaching (HoBt) PCT.

The computers offer health information and advice for patients, including updates on local health events and initiatives.

The initiative includes a pilot scheme to improve management of diabetes, and a "picture prescription" to assist those patients who do not speak English in understanding dose instructions.

Zahid Chishti of Sparkbook Pharmacy praised the screen as providing a "trusted source of information from a trusted centre".

He said: "It's an add-on, it's not instead of a pharmacist. It's a way people can get more information, and it gets patients upskilled – if they want more information they can look it up."

Around 70 per cent of HoBt PCT patients are from ethnic minorities, and the picture prescription function would help pharmacists communicate with patients from these communities and improve compliance, Mr Chishti added.

HoBt PCT head of medicines John Morrison said the screens would help patients who did not feel comfortable asking for advice over the counter. "In a busy pharmacy many people find it difficult to ask for advice on their condition. The health information touch screens are ideal," Mr Morrison said.

AAH: 'Do more to help patients online'

Pharmacists could do more to help patients use reliable online resources to help manage their health, AAH has said.

The comments came after NHS figures showed more patients were using the internet to find health information than in 2009. A third of those patients then did not make GP appointments, which could save the NHS £44 million a year.

AAH head of marketing services Ajit Malhi said pharmacists could do more by "encouraging patients to set health goals and manage their own wellbeing with the help of approved interactive websites."

The NHS Choices 2010 annual report showed there had been 10 per cent more visits to the site compared with 2009. And an Imperial College study showed that 70 per cent of people use the internet to search for health information.

Newham concerns over £30,000 IT fee

Pharmacy contractors in Newham PCT have raised concerns over the £30,000 cost of encryption software that they have been told they must install in the coming months.

The software enables pharmacists to submit all information about enhanced services electronically, and the cost works out at about £500 per pharmacy.

Local contractor Jignesh Patel, of Rohpharm pharmacy, told C+D: "This is an NHS issue; it shouldn't be pharmacies footing the bill.

"Most enhanced services require you send data off to the PCT and it needs a secure method of transmission."

Mr Patel said he was concerned services payments would be difficult to obtain if the correct software was not installed in pharmacies. And head of information services at PSNC Lindsay McClure said the Information Commissioner had warned regulatory action could be pursued if health professionals lost unencrypted data in the future.

She said: "Expert guidance on encryption of computers should be sought from system suppliers."

The PCT told C+D the figure was a provisional quote and that by purchasing software for all pharmacies in the area, contractors would ultimately pay less.

The Department of Health (DH) said the PCT was implementing central government guidelines and that pharmacy contractual funding took into account regulatory burdens. **HF**

Cosmetics taken in Boots raid

Police are searching for two men after £3,000 of beauty products were stolen from a Boots store in Somerset last week.

The Boots, in Wincanton, was robbed at around 10am on Tuesday November 2, with a large amount of cosmetics taken.

It is believed two men wearing "very distinctive clothing" were involved, a police spokesman said. The robbery was captured on closed circuit TV.

Avon and Somerset PCSO Mandy Forsey said Boots was keen to prosecute, adding the items may be sold at car boot sales or markets.

A Boots spokesperson confirmed the incident had occurred at the store, and that Boots was assisting the police with enquiries. **CC**

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Media pill outrage: is it fair?

As controversy surrounding the Isle of Wight's contraceptive pill service reaches the House of Commons, **Hannah Flynn** asks what pharmacy stands to gain from offering such services

The news that pharmacies on the Isle of Wight have launched a scheme that will allow pharmacists to dispense a month's worth of the progesterone-only contraceptive pill without a prescription has caught the attention of the nation.

Much of the furore has focused on the fact that the scheme is open to women over the age of 13, meaning pharmacists could supply under-16s with the pill without their parents' knowledge.

The scheme was criticised in the national press, and at the height of hysteria the island's Conservative MP Andrew Turner submitted an oral question to health minister Andrew Lansley over the plans, claiming: "Many of my constituents are horrified."

With so much public unease, it's easy to wonder what such a scheme actually brings for the profession.

The scheme on the Isle of Wight will mean that if a patient under the age of 16 presents at a pharmacy for EHC then they will be given one month's supply of the contraceptive pill if the pharmacist deems it appropriate. They will also be referred to an outreach nurse or to their GP. Patients over the age of 16 will be referred to the sexual health service. And all patients will also be offered chlamydia screening and a supply of condoms.

The decision to offer the pill to women over the age of 13 differs from a similar scheme in Southwark and Lambeth PCTs, which only offers the contraceptive pill to women presenting over the age of 16, but it is in line with case law. A decision by the House of Lords in a 1985 case ruled that women under the age of 16 do have the legal capacity to consent to medical treatment without parental consent. And health secretary Andrew Lansley alluded to this in the House of Commons when asked about the scheme, stressing that young persons are competent to make such decisions.

Chief officer of Hampshire & Isle of Wight LPC Mike Holden says the negative publicity has not been helpful, but he says much of the commentary has been from ill-informed people. He says: "Everyone needs to understand it is not [primarily] aimed at people who are under 16. It is for people who are using EHC, so these are people who have already decided to engage in underage sexual activity."

"You can't be tasked with making sure people are informed before opening their mouths"

MIKE HOLDEN, CHIEF OFFICER, HAMPSHIRE & IoW LPC

Pharmacist Cuthbert Chirinda completed training at Kings College London before he began offering the pill at his pharmacy as part of the Lambeth and Southwark PCTs pilot. He says that patients have been impressed by the opportunity to obtain the contraceptive pill at his pharmacy and he completed nearly 400 consultations during the one-year pilot.

Mr Chirinda says: "I think we have had a lot of improvement and patients were excited about it. We have done 400 consultations and patients like the fact that they didn't have to book."

Patients also appear to be benefiting from the scheme, as Mr Chirinda has seen a drop in the number of women presenting for EHC since he started the pilot. And 40 per cent of the patients receiving the pill in the pilot were first-time pill users, suggesting they would not have accessed long-term contraception elsewhere.

The patient benefits seem to be clear, but it still remains to be seen how much of an impact the negative coverage of the scheme will have on community pharmacy.

Industry leaders are convinced that patient confidence will not be affected by this latest pharmacy story, though. Chair of the RPS English Pharmacy Board Lindsey Gilpin says that she feels the backlash has more to do with attitudes to sexual behaviour in young people than people's attitude towards pharmacists, but that the profession could do more to target those in positions of authority.

As Ms Gilpin says: "People do still trust their pharmacists."

And a spokesperson from the NPA says the matter has been dealt with well by the Isle of Wight, adding: "The local NHS and pharmacy representatives on the Isle of Wight handled the matter with the confidence you would expect from people with the facts behind them."

Mr Holden points out that the criticism seen last week came from a few uninformed commentators and says: "You can't be tasked with making sure that people are informed before opening their mouths – and you can't be held accountable for that."

So whatever the latest coverage may have been, it seems that the Isle of Wight scheme could well be good for the sector as a whole.

If the public are convinced by the scheme, as patients were by the London equivalent, it could enhance the sector's profile in the clinical services arena.

Pill perspectives

"This service has been provided with consummate professionalism."
Sue Sharpe, CEO, PSNC

"Nowhere else, I am told, shares that approach. Many of my constituents are horrified."
Andrew Turner, Conservative MP, Isle of Wight

"The coverage of the service illustrates the need for attitudes and public awareness to be brought up to speed with developments in community pharmacy."
Stephen Fishwick, head of external relations, NPA

Button down kids' cold & flu symptoms this winter

Supported by a major nationwide TV campaign

When children over six need effective relief from colds, flu and nasal symptoms, recommend CALCOLD Six Plus. You can rely on it throughout the season to quickly tackle their runny noses, sneezing, fevers, sore throats, aches and pains, and ease their breathing.

Trust the makers of Calpol to have kids' colds and flu covered

CalCold Six Plus Product Information:
Presentation: Strawberry flavour solution containing 120mg Paracetamol and 12.5mg Diphenhydramine hydrochloride per 5ml. **Uses:** Treatment of mild to moderate pain in children 6-12 years, including teething pain, headache, sore throat, aches and pains for the symptomatic relief of influenza, feverishness, feverish colds and associated symptoms of runny nose and sneezing. **Dosage:** *6 - 12 years:* 10ml - 20ml three times daily. **Contraindications:** Use in children under 6 years; hypersensitivity; with or within two weeks of receiving MAOIs; large doses of anti-histamines may precipitate seizures in epileptics. **Precautions:** Not more than 3 doses should be taken in 24 hours. Not to be used for more than 3 days without the advice of a doctor. Caution in hepatic or moderate to severe renal dysfunction, urinary retention, angle-closure glaucoma or symptomatic prostatic hypertrophy; avoid use with alcohol or other sedating medicines; fructose intolerance; may cause drowsiness; interaction with domperidone, metoclopramide, colestyramine, anticoagulants, anticonvulsants and oral contraceptives; may have an additive muscarinic action; may potentiate effect of alcohol, and other CNS depressants. See SPC for further details. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Hypersensitivity including skin rash; blood dyscrasias; drowsiness, paradoxical stimulation, headache, psychomotor impairment, gastrointestinal disturbance, dry mouth, urinary retension, blurred vision, thickened respiratory tract secretions. Rarely hypotension: palpitations, tremor, convulsions. Chronic hepatic necrosis and papillary necrosis have been reported. See SPC for further details. **RRP (ex-VAT):** 100ml: £2.98. **Legal category:** P. **PL holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG **PL no:** 15513/0145. **Date of prep:** September 2009

ID: 06175

McNeil

Actavis introduces First Resort range

Actavis has announced the launch of its First Resort range. The two initial products launched are Double Action Pain Relief, containing diclofenac, and Period Pain Reliever, containing naproxen.

Both of these NSAIDs are recent POM to P switches.

The two oral analgesic pain relief products will form part of a larger range under the First Resort brand name, with further launches to follow, according to Actavis.

Market focus

- The adult oral analgesics market grew by 3 per cent in 2009.
- Pharmacy's share of the adult oral analgesics market is worth £70 million.

Source: Kantar Worldpanel value sales, 52 weeks to November 29, 2009

Prices: £3.99/18 (Double Action Pain Relief); £3.99/9 (Period Pain Reliever)
Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Actavis
Tel: 0800 373573

Special Recipe Chocolate launches with new packaging

Ernest Jackson & Co has announced the repackaging of its Special Recipe Chocolate range for diabetic, low GI and sugar-restricted diets.

The move has been timed to coincide with the run up to Christmas, according to the company.

The new packaging aims to give the range an indulgent and premium look, it says.

The range is sweetened with fructose and comes in five varieties: smooth milk chocolate, fine plain chocolate, smooth milk chocolate and chopped nuts, praline-filled milk chocolate and mint-filled plain chocolate.

Prices: £1.93/100g
Pip codes: 235-5667 (smooth milk); 235-5717 (smooth milk and chopped nuts); 235-5733 (praline-filled); 235-5725 (fine plain); 235-5741 (mint-filled)
Ernest Jackson & Co
Tel: 01363 636100

Lotus Olbas Facial Tissue launch

Lotus and Olbas have announced the launch of Lotus Olbas Facial Tissue, which will be supported by a PR campaign.

The move follows the launch of the Lotus Olbas Pocket Pack in 2007, which has driven incremental category growth to the pocket pack market, according to a spokesperson for the joint venture.

The tissues combine vapour-releasing oils with a premium tissue brand and therefore present added value for the consumer by removing the need for two separate purchases, the spokesperson adds.

The PR campaign will target the Sunday newspapers and supplements, women's consumer press and regional radio.

Price: £2.29
Pip code: 357-8887
Tel: 01204 673522

Email us with your letters
haveyoursay@chemistanddruggist.co.uk

Letters

Fight back: making MURs matter

The publication of the National Institute of Health's (NIH) research on financial incentives and the performance of primary care practitioners in the NHS came as a significant blow to pharmacists across the country.

However, I believe pharmacists must view the report as an opportunity to not only improve the number and quality of MURs, but also to create an evidence base for the valuable role pharmacists already play in the primary healthcare arena. I've identified some key areas which, with small modifications, I believe will help address the challenges raised by the NIH.

1. Team work and time management Over the past 10 years, the growing role of pharmacists in community has been matched only by the growing number of prescriptions dispensed. Subsequently, time management is one of the biggest challenges facing pharmacists today. To help, I would advise pharmacists to seek to involve all members of the pharmacy team in the delivery of effective MURs.

Team work is not only important in your pharmacy but also in the wider primary care profession, particularly practice nurses. Without appropriate collaboration we risk fragmenting services and duplicating efforts. Practice nurses are ideally placed to perform disease reviews while pharmacists are in the perfect position to provide medicines reviews.

2. Gaining customer confidence Traditionally, pharmacists have provided patients with advice on the use of treatments reactively. As such, MURs can represent a step out of the comfort zone both for pharmacists and patients. Effective communication is key; pharmacists should take the time to explain to patients why the review is needed and how it may benefit their care.

3. Measuring and demonstrating impact Measuring patient outcomes is key to ensuring MURs are completed effectively, benefiting patients and pharmacists. But paper-based data collection systems are seen as cumbersome and complex, and pharmacists are reluctant to use them, citing time constraints and administrative burden.

To help overcome this challenge, and to encourage consistency in reporting, PLUS from GSK has developed a simple online tool that helps pharmacists conducting asthma MURs to easily collect patient outcomes data and to audit their asthma MUR programme accordingly. Where this type of support is not available, I would encourage pharmacists to approach local GP surgeries to agree both the type of information that might be useful for collection and how it will be conveyed.

Whatever the methodology, there is little doubt community pharmacy needs to generate an evidence base that quantifies and validates the invaluable work that is undoubtedly being conducted in pharmacies up and down the country.

Linda Stephens
National pharmacy advisor
GlaxoSmithKline UK

We deserve respect from the government

"IT FEELS AS IF THE PARCEL I SEND TO THE NHS PRICING DIVISION CONTAINS NOT PRESCRIPTIONS BUT LOTTERY TICKETS, THOUGH WITHOUT THE JACKPOT"

It's a few years now since our last refit, and we could do with spending some money on a new carpet, furniture and a second consultation room. This is hard enough to budget normally as our prescription payments vary greatly from one month to the next. But we know January brings another category M famine of indeterminate depth, and now we learn that "ludicrous" pricing errors are still being made. It feels as if the parcel I send to the NHS Pricing Division contains not prescriptions but lottery tickets, though without the jackpot. The C+D reported community pharmacists as feeling "flabbergasted" by these errors – I can only assume they felt unable to print the words most of us would really use!

An LPC was reported describing our payments system as "morally indefensible". This was a very timely comment, because I'd read a training paper a few days before about clinical ethics. The paper laid out the five morals that should underpin any ethical process, which are "do good", "do no harm", "informed choice", "justice", and "respect".

The current arrangement certainly doesn't do me any good, since I need an overdraft or other financial float of up to 20 per cent of my payment and the lack of assurance I feel in NHS Prescription Services certainly harms my confidence to invest in the business. I have no choice – informed or otherwise – as to the payment structure and I am desperate for a legal challenge to the contractual justice of the current reimbursement system. All that being said, it is my choice to be a contractor, and I entered into it knowing and accepting the payment arrangements, so maybe these arguments are false? But what about the fifth moral – respect?

We know patients love us, clinicians respect our profession, and politicians laud pharmacy for our services. So why does our payment system demonstrate such little respect for our profession? No one else would accept a situation where your pay packet varied by so much, and so unpredictably, from one month to the next.

We deserve the respect from government of a reimbursement system that is ethically based. One where we are not penalised for the errors of others, and where profitable buying of stock is not penalised. A few weeks ago a government minister criticised a large non-medical company, describing the action of requesting retrospective rebates from suppliers as a mistake, so what does that say about the prescription payment system?

This mess needs sorting out, and while I understand the PSNC saying there isn't a magic bullet, I feel someone needs shooting.

Have you been hit by prescription price errors?

haveyoursay@chemistanddruggist.co.uk

Tackling the ever-increasing rise in scripts

Last week, Lord Howe visited one of our pharmacies in Vauxhall, south London. It was apparently his first visit to a community pharmacy and an opportunity to talk to him about the role for community pharmacy in the new NHS landscape.

There was one question on both our minds: how can pharmacy help in delivering cost-effective healthcare that meets the needs of patients and the health service?

The profession and the government want to expand pharmacy beyond the dispensing role and to reflect this in a change from a volume-based contract to one more focused on clinical services and delivery of health outcomes.

But let's put aside for now the complexities around evolving the pharmacy contract and the re-engineering of finances this will entail. There is also a very practical challenge to take into account: the physical capacity of pharmacy to deliver an expanded role.

How can pharmacy undertake the greater level of patient engagement that is our shared ambition, while also continuing to process ever-increasing volumes of prescriptions?

Efficiency is the buzz word in the NHS – and it's critical here. Ensuring the right skills are deployed in the right way will make a huge difference, as will technology.

Automated dispensing potentially has a role to play in creating a more patient-focused service. And then there's the electronic prescription service (EPS). It seems as though this particular boat has been sitting out at sea for a very long time. Of course, there are some aspects of EPS that still need to be worked through, but it does present a part of the solution to the question of how pharmacy will cope with an expanding role.

All good news. But, as always, it's not quite that simple. There's the PCT question.

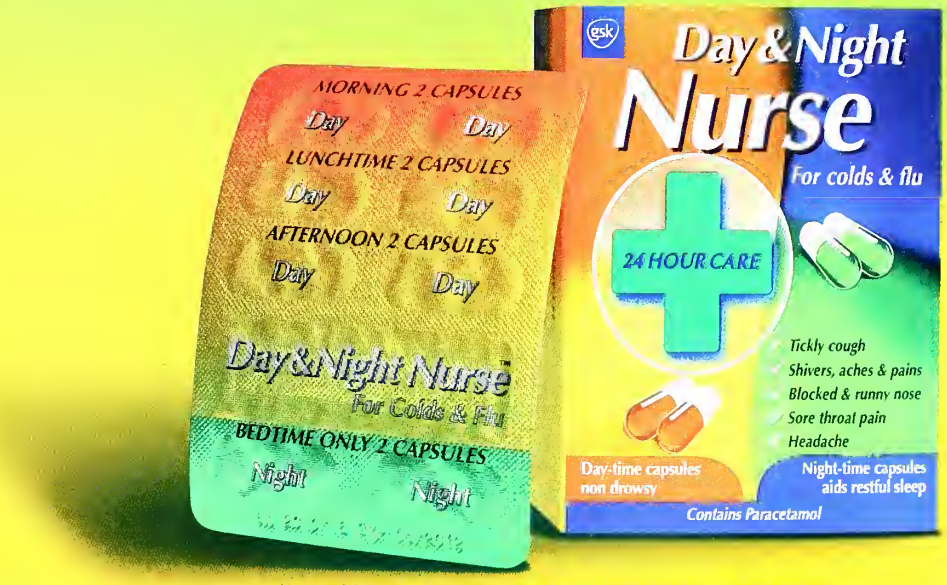
With PCTs on the verge of disappearing, and as we near early implementation of EPS release 2, who's going to make sure it succeeds? Specifically, in the vacuum caused by the re-engineering of the NHS, how will the PCT registration authorities manage smartcards? Who will manage the EPS2 rollout project teams when the PCTs are in a state of decline? Who will apply for secretary of state directions to obtain a GP authority to write electronic prescriptions with a digital signature?

Ultimately, how interested can we really expect PCTs to be in EPS with everything else that's going on around them and with the threat of unemployment hanging over their heads? It's important that we remember pharmacy has money riding on this. In a time of significant change across the NHS, it's up to all of us to make sure it stays firmly on the radar.

Andy Murdock, pharmacy director, Lloydspharmacy

"ENSURING THE RIGHT SKILLS ARE DEPLOYED IN THE RIGHT WAY WILL MAKE A HUGE DIFFERENCE, AS WILL TECHNOLOGY"

A TEAM THAT DOESN'T CLOCK OFF.



Day-time: Paracetamol, Pseudoephedrine, Pholcodine
Night-time: Paracetamol, Promethazine, Dextromethorphan

FOR COMPLETE 24HR RELIEF FOR COLDS & FLU

Day & Night Nurse Capsules. Product Information. Presentation: *Day Time Capsules*: Capsule with opaque yellow body and opaque orange cap containing Paracetamol 500 mg, Pseudoephedrine hydrochloride 30 mg, Pholcodine 5 mg. *Night Time Capsules*: Capsule with opaque white body and opaque bright green cap containing Paracetamol 500 mg, Promethazine hydrochloride 10 mg, Dextromethorphan hydrobromide 7.5 mg. **Uses:** Short term relief of the symptoms of colds and influenza during the day or at night. **Dosage and administration: Adults and children 12 years and over:** *Day Time Capsules*: 2 capsules every 4 hours if needed up to 6 capsules in 24 hours. *Night Time Capsules*: 2 capsules not more often than every 4 hours. **Children under 12 years:** Not to be given. **Contraindications:** Known hypersensitivity to ingredients, hyperexcitability, cardiovascular disease, hypertension, diabetes, epilepsy, hyperthyroidism, phaeochromocytoma, closed angle glaucoma, prostatic enlargement, severe liver or kidney disease and in patients with asthma, chronic bronchitis and chronic respiratory disease. Patients taking, or within two weeks of having taken, MAOIs. **Precautions:** Avoid use with other paracetamol-containing preparations. Do not exceed the stated dose. Do not use for more than 7 days except on medical advice. Not recommended in pregnancy and lactation. May reduce the effect of antihypertensive drugs, and increase the risk of arrhythmias associated with digoxin. May increase sedative effect of alcohol, barbiturates, hypnotics, narcotic analgesics, sedatives, tranquilisers. Caution required in patients taking warfarin or other coumarin anticoagulants, ispenidone, metoclopramide and colestyramine. The night capsule may cause drowsiness. If affected, do not drive or operate machinery. **Side effects:** May cause nausea, vomiting, diarrhoea or constipation, epigastric pain, headache, tinnitus, irritability, nightmares, anorexia, difficulty in micturition, tachycardia, tremors and skin rashes. Drowsiness, dizziness, psychomotor impairment, antimuscarinic effects (such as urinary retention, dry mouth, blurred vision), disorientation, restlessness. There have been very rare reports of blood dyscrasias including thrombocytopenia and agranulocytosis but these were not necessarily causally related to paracetamol. Hypersensitivity reactions including rash and photosensitivity reactions have been reported. **Overdose:** Immediate medical advice should be sought in the event of an overdose, even if the patient feels well, because of the risk of delayed, serious liver damage. **Legal category:** P. **Product licence number:** PL 0079/0067. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 24 Capsules (16 day-time capsules, 8 night-time capsules) £4.99. **Date of Preparation:** March 2010. **Day & Night Nurse** is a trademark of the GlaxoSmithKline group of companies.

Your Shout

Whether you want to share your experiences, get something off your chest, or ask C+D to put your questions to the industry's experts, Your Shout is your opportunity to do so. Get in touch with us by emailing: **haveyoursay@chemistanddruggist.co.uk**

Race to build the evidence base

Community pharmacy must act now to prepare for a quality-focused future under the NHS white paper, says LPC secretary **Hemant Patel**

Health service commissioning decisions should be made on the basis of values, evidence and resources. But presently most commissioning decisions in the NHS are based on culture, tradition and political clout.

Health secretary Andrew Lansley aims to change this, as outlined in the recent NHS white paper.

Under the proposed system, the NHS outcomes framework will be based on the principles of effectiveness, patient safety and patient experience – so the evidence required will change.

The white paper proposes patients will: have access to more healthcare information, be able to rate and record their experiences; have greater control of their records; and have extended choice of provider and services.

This is encouraging as it puts pharmacy on a more level playing field – if we get the strategy for gathering evidence and using it. However, as pressure on resources (staff, technology and premises) is increasing, scrutiny by a better informed public, and expert scrutiny on behalf of the public, will also be increasing. This is bad news for some pharmacists whose clinical skills are poor, and where communication is poor. The good news for the profession is that we have 12 months to get ready.

3 pillars of quality – an NHS definition

1. The effectiveness of the treatment and care provided to patients
2. The safety of the treatment and care provided to patients
3. The broader experience patients and their carers have of the treatment and care they receive

A change of culture

To make pharmacies evidence-based providers of health services, it is important to develop the right attitudes, systems, and cultures – and it is absolutely necessary to change the structure, function, and behaviour of the pharmacy network and individuals working within it.

In the context of the white paper, pharmacy needs to agree what outcomes to aim for, what evidence to generate, what values to adopt, where to innovate and what resources are needed to deliver quality pharmacy services. Talking about resources alone will result in a reduction in credibility when others, including newcomers, thrive.

Commissioners will be considering the following evidence from pharmacy:

- Is the evidence base credible?
- Is the evidence of best quality?
- What is the gain over current practice?
- What is the change in patient safety, satisfaction, preference and expectation?
- What is the change in cost?

Naturally, where there is potential for more good than harm and to meet the cost considerations, the response would be favourable.

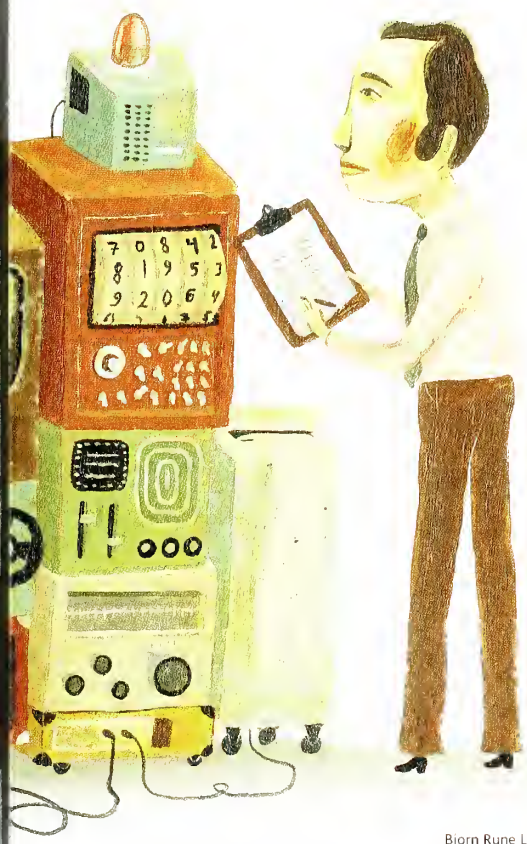
What would almost certainly not be asked, is whether the model built on evidence and knowledge is transferable to other settings and professional groups? And, what can be done to make a model work in other settings?

Where there are good reported outcomes, they may not be realised in all settings as they depend on the quality and commitment of individual pharmacists and their teams. Performance in community pharmacy is widely variable. To ensure that the public receives the maximum health benefit at the lowest possible cost and risk, we need evidence that not only is the process evidence-based with good quality management procedures in place, but also that the practitioners have the necessary commitment and capacity to deliver services.

Ideally, and for the sake of efficiency, evidence should be a by-product of well-designed practice and recording activity. Additional evidence can then be captured by research and audit. But pharmacy systems are not designed that way. There is a heavy price to pay for this: exclusion from further growth and opportunity.

Pharmacy faces a tough challenge in the white paper and will be forced to act differently and more clinically. So, sooner rather than later, the LPCs, supported by all the national pharmacy bodies, must get the following message to contractors and pharmacists:

1. Face the hard facts, and build a culture in which people are encouraged to tell and record the truth, even if it is unpleasant.
2. Be committed to fact-based decision-making, which means being committed to getting the best evidence and using it to guide actions.
3. Treat your pharmacy as an unfinished prototype of a future pharmacy and encourage experimentation and learning by doing.
4. Look for the risks and drawbacks in what prescribers prescribe and you supply as even the best medicine has side effects.
5. Avoid basing decisions on untested but strongly held beliefs, what you have done in the past, or



Bjorn Rune Lie/Ikon Images

on uncritical benchmarking of what winners do.

Learning from mistakes

In parallel, we need a clear message from the GPhC that it will support recording of truth and managing the aftermath. In pharmacy, there is a perception (justified or not) that the motivation to seek retribution is strong. It can, and often does, get in the way of another valued objective: learning. The profession and pharmacists would be well-served to understand the trade-offs between learning and punishment and make wiser decisions that help us learn from our mistakes.

Partnership between GPs and pharmacists is vitally important to patient care. And so there should be a duty of clinical partnership that should include joint learning and support. After each adverse incident, there should be a joint duty to file a report for learning and for that learning to be shared with other colleagues. The emphasis for the NHS and professionals is the need to change from punishment to learning and accountability.

Increasingly, when professionals do not follow evidence-based practices or procedures (when they make errors) the professionals are blamed. Well-trained professionals, such as pharmacists, are not supposed to make errors. When they do make errors, they must have been incompetent or negligent, or it was someone else's fault. Errors never get reported because they are evidence of and result of 'individual failure' and no one wants to look bad. Yet in any human system, errors are inevitable. The proximal causes are individual but the root causes are systemic. These result from poor design, faulty maintenance (quality control), and erroneous management decisions.

Also, bad management and superintendents' decisions can result in unrealistic workloads, lack of tools, inadequate training, and demanding volume expectations that can force pharmacists to make errors.

Based on my extensive experience as an LPC secretary, I can predict departures from routine (a problem) will lead to two types of reactions:

- A bias to search for a pre-packaged solution (a protocol) before resorting to more strenuous knowledge-based functioning.
- A dependence on 'expertise' consisting of an extensive repertoire of protocols schemes and rules, with infrequent resort to knowledge-based functioning.

While it is helpful to start with as everyone is under pressure to get going, this approach has long-term detrimental value as the behaviour is then robotic and not capable of responding to varied human and situational need.

The NHS in England has failed to invest in pharmacy to make it a clinical profession basing decisions on evidence. Where are the incentives to change behaviours and tools such as electronic links to the world of knowledge, expertise and advice for pharmacists? In Scotland, pharmacists have tools like these to develop evidence-based practice.

To enter the radically new world, where decision-making will be based on structured evidence, we need a root and branch inquiry to develop a multi-level platform for evidence-based pharmacy practice and secure a future for good pharmacists.

The journey from a supply-based system to a knowledge-based system will not be easy, but we can take timely action now to make things easier.

Hemant Patel is secretary of North East London LPC, and former president of the RPSGB

"Evidence is critical"

Portsmouth's government-backed Healthy Living Pharmacy initiative has just released an interim outcomes report. Project lead Deborah Evans tells C+D why evidence-gathering is fundamental to the scheme – and to community pharmacy as a whole

We recognised from the outset that generating evidence was going to be important, so it was an underlying principle of the Healthy Living Pharmacy initiative.

To facilitate that evidence-generating process, we set up an online web-based recording system for the respiratory MUR service so we could record not just activity on a daily basis but also the interventions and the people we're reaching. The PCT can access that information at any time.

Recording for the alcohol audit was originally paper-based but now, with a new enhanced service, that's got an online version.

Evidence for services is needed because if you're commissioning a service you need to understand what value that's getting and what you're getting for commissioning at a local level and to inform local commissioning decisions. On a more global level, the work in Portsmouth is influencing policy nationally, so we need to know what's happening to influence national decision-making.

We're also giving feedback to the pharmacy community to say: "This is what you've achieved." So it's motivational, as well.

We have made the interim outcomes report available to help inform policy, to help inform future commissioning of services – and I believe it will be useful for other areas making a decision about whether this is something that they want to move forward.

It's been very positively received by people influencing policy as well as those engaged in the project.

Evidence is critical for community pharmacy. It's fundamental that we can demonstrate the difference that we are making, not just for local feedback but also for the commissioners and other healthcare providers, and also to the public, who want quality assurance of what we can do.

My advice to others gathering evidence on services would be to consider why you're collecting the evidence, what the evidence should be, what questions you're trying to answer by gaining evidence, and to make it as easy as possible to collect and interpret it.

Update

Your weekly CPD revision guide

60-second summary

Why read this article?

Sore throats typically occur two to three times a year in adults. This Update looks at the causes of sore throat and treatment, as well as when pharmacists should refer for further investigation.

What are the causes of sore throat?

Viruses are associated with 85 to 95 per cent of sore throat cases in adults. In children the incidence of viral-associated sore throat varies depending on age. Bacteria can also be associated with sore throats but this only occurs in approximately 10 per cent of cases in younger children and adults. In children between five and 15 years, group A ß-haemolytic streptococcus is the cause in about 30 per cent of cases.

When should antibiotics be prescribed?

NICE recommends that antibiotics should not be used, or prescribing delayed in patients with acute sore throat who are not at risk of additional complications. It is important patients are advised that antibiotics would have a limited effect on symptoms, even if the cause is bacterial. Around 40 per cent of patients will recover without treatment in three days.

To get Update emailed to you each week, register for C+D's CPD newsletter at www.chemistanddruggist.co.uk/register

Acute sore throat

The causes and management of sore throats, and when to refer to a GP

Damien McNally MRCGP
Michaela Scheiner MPharm

Sore throats are a common and troublesome affliction for all ages. On average, they typically occur two to three times per year in adults, although dry throats may be much more common. In children this incidence may be much higher, owing to their naive immune system. The term 'sore throat' is a general one and encompasses a wide range of symptoms and causative agents. Therefore, a sore throat may differ greatly between individual patients based on their immune state, the duration of the sore throat, the symptoms displayed and the causative agent. Contrary to popular belief, in only a small percentage of cases is the causative agent a bacterial infection.

Causes and risk factors

The most frequent cause of sore throats is a viral infection, with viruses associated with 85 to 95 per cent of sore throat cases in adults.[1]

In children the incidence of viral-associated sore throat varies depending on age. For example, in children aged between five and 16 years, viruses cause 70 per cent of sore throats, whereas in children younger than five years of age, this figure is 95 per cent.[1]

Bacterial infection can also be associated with sore throats, but this only occurs in about 10 per cent of cases in younger children and adults. When bacteria are the cause of the sore throat, the most common bacterial cause is group A ß-haemolytic streptococcus (GABHS, also known as streptococcus pyogenes, colloquially known as strep throat).[1] In children aged between five and 15 years, GABHS is the cause of sore throats in about 30 per cent of cases.[1]

Environmental factors, such as air conditioning, low humidity and low temperature, indoor heating, allergens and pollution may also cause dry and sore throat. A sore throat may be an indication of an underlying condition.

Examples of underlying conditions for which a sore throat may be a marker include the complications of infections, glandular fever, peritonsillar abscess, oral thrush and non-infective diseases (eg allergy and very rarely throat cancer, which is largely limited to older smokers).

Red flags and referrals

Sore throat may be a red flag for certain serious conditions. For example, in patients taking carbimazole for overactive thyroid activity, a sore throat may be one of the early signs of agranulocytosis, a severe lowering of the white blood cells. Owing to the serious conditions that may be associated with a sore throat, pharmacists should refer a patient to a GP if:[2]

- the patient cannot swallow liquids
- the sore throat is recurrent or lasts more than seven days
- the patient experiences prolonged (over three weeks) or repeated bouts of hoarseness
- the patient develops a red rash
- the patient has a persistent sore throat with heavy night sweats and enlarged glands
- the patient develops earache, which does not resolve within 48 hours
- the throat is painful, has not improved within 48 hours and there are no cold or influenza symptoms
- glands in the neck are swollen with no other symptoms or fail to go down within three weeks of a sore throat clearing
- the patient has had rheumatic fever.

Pharmacists should question patients around the above criteria to establish if the sore throat could be a sign for referral to the GP, or hospital if a sore throat is associated with breathing difficulties.[2]

Treatment

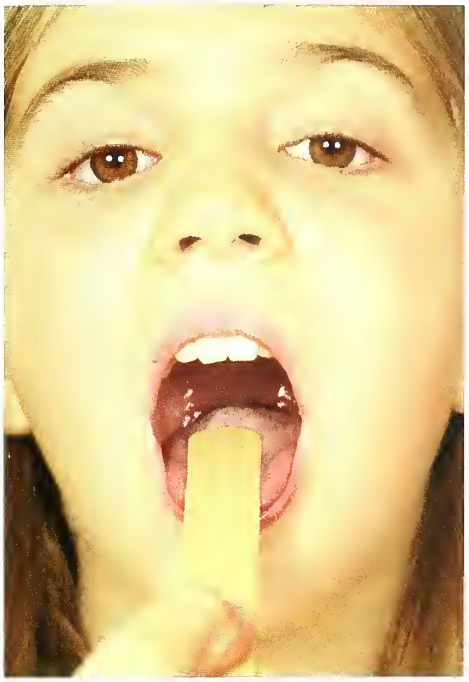
Around 40 per cent of patients will have recovered without treatment within three days and 80 per cent within seven days.[3]

The management of an acute sore throat therefore revolves around providing relief from the existing symptoms (eg local pain and inflammation), removal of the underlying causes and prevention of secondary complications.[4] These targets can be achieved through a number of therapeutic approaches, such as analgesics, local anaesthetics, antiseptics, anti-inflammatory agents and, if required, antibiotics.

Few hard guidelines exist for the management of sore throat. One example of a treatment algorithm coming into effect in Northern Ireland is available in the full version of this article online at www.chemistanddruggist.co.uk/update.

Nevertheless, when patients present at the pharmacy, pharmacists should provide patients with general advice about their condition and give overall treatment recommendations, such as getting plenty of rest and drinking plenty of fluids.

Pharmacists should also recommend specific OTC remedies for treating acute sore throat. The range of OTC options available should allow treatment to be tailored, depending on the type



Streptococcal infection is the cause of sore throat in 30 per cent of children aged five to 15 years old

of sore throat and what patients want from their therapy.

Acute sore throat OTC treatments are available in many different formulations, including tablets, sprays, gargles and lozenges – the latter being the most frequently used formulation within the UK. Each of the treatments has its respective advantages and disadvantages.

For example, data show that, compared with sprays and gargles, lozenges have considerable advantages in terms of the delivery of active ingredients. This is because of a prolonged delivery due to an increased mouth residence time of lozenge.[5] In contrast, a proportion of throat sprays is immediately swallowed after application,[5] and with gargles there is an associated gag reflex, restricting the delivery of active ingredients to only the anterior oral cavity and not all affected areas of the throat.

Oral analgesics, such as paracetamol and ibuprofen, are effective in reducing pain associated with acute sore throat.[2] However, despite their efficacy in providing pain relief, oral analgesics have limited effect on sensorial aspects, such as soothing, coating, cooling and warming.

Throat lozenges, on the other hand, have been associated with many of these sensorial benefits. In addition, some contain active ingredients that possess one or a combination of antibacterial, antiviral, anti-inflammatory and local anaesthetic properties. For example, recent data have shown that the active ingredients of amylmetacresol (AMC) and 2,4-dichlorobenzyl alcohol (DCBA) throat lozenges also possess local anaesthetic properties[6] in addition to some antiviral and antibacterial properties. Furthermore, a recent randomised controlled trial of the use of AMC/DCBA throat lozenges showed reduced throat soreness, an easing of difficulty of swallowing and improved functional impairment scores compared with placebo lozenges.[7]

Preference of treatment varies between individuals. Some patients want relief with sensorial effects, while others want more hard-hitting relief, such as powerful analgesic, anti-inflammatory or anaesthetic effects. Anaesthetic effects can be polarising for patients; a recent questionnaire survey on the use of a range of AMC/DCBA, AMC/DCBA/lidocaine, and hexylresorcinol throat lozenge formulations in healthy volunteers showed an anaesthetic effect for AMC/DCBA lozenges and a more pronounced numbing effect was reported with hexylresorcinol and lidocaine, with higher concentrations increasing the effect. Indeed, a numbing effect has previously been reported in patients taking AMC/DCBA lozenges, which contain 10mg of lidocaine.[8] Lidocaine (8mg) sore throat lozenges have also been associated with improvements in pain intensity and meaningful pain relief.[9] Thus, with the selection of OTC treatment options available, some patients may prefer to choose a stronger lozenge regardless of the severity of their sore throat.

When recommending a throat lozenge with local anaesthetic effects, it is important for pharmacists to point out that the action of any local anaesthetic agent may affect the perception of the temperature of hot drinks.

An additional treatment approach for acute sore throat is the use of complementary medicine. A number of traditional, herbal and complementary treatments are available and have a weight of anecdotal support for their use. However, they are limited by their lack of strong clinical evidence. A recent review by the Cochrane Collaboration stated that the efficacy of Chinese herbal medicine for the treatment of sore throat is controversial and questionable. Furthermore, it stated that they could not recommend any kind of Chinese medical herbal formulation as an effective remedy for sore throat.[10] Owing to the possibility of interactions, it is advisable to establish if a patient has been using complementary remedies prior to recommending an OTC treatment.

Antibiotic prescribing

Nice has developed a guidance document on antibiotic prescribing for respiratory tract infections in adults and children that includes recommendations for the management of patients with acute sore throats. The recommended strategies for prescribing antibiotics are based on the individual diagnosis of the patient, and include no, delayed or immediate prescribing.

The guideline indicates that a delayed prescribing or no prescribing strategy should be offered to patients with acute sore throat who are not at increased risk of developing complications. Because patients occasionally view antibiotics as a cure for all ills, it is important for health professionals to reassure them that antibiotics are not required as they would have limited effects on the symptoms of sore throat and may be subjected to potential side effects. Indeed, the aetiology of acute sore throat means that for the majority of cases, the cause of the sore throat will not be a bacterial infection and so treatment with antibiotics is not warranted. In cases of bacterial sore throat where antibiotics are used, the absolute benefits have been shown to be only modest and take time to show any effect. Therefore, it is important for the GP to highlight the benefits of alternatives to antibiotics and refer patients on to the pharmacist.

Non-drug prescribing

Alongside recommendations for OTC treatments, pharmacists may provide patients with general recommendations for the treatment of their sore throat. These include getting sufficient rest and making sure that they remain hydrated. If a patient presents with persistent sore throat, rheumatic fever or indeed any of the signs mentioned earlier, they should be referred back to the GP or hospital.

The [illegible] is available in the full version of this article online at www.chemistanddruggist.co.uk/update

Damien McNally is a GP partner in Belfast

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the [illegible] this Update article online (p20).

Useful information

- Nice Clinical Guideline 69. Respiratory tract infections – antibiotic prescribing. Prescribing of antibiotics for self-limiting respiratory tract infections in adults and children in primary care. July 2008. www.nice.org.uk/nicemedia/live/12015/41323/41323.pdf).
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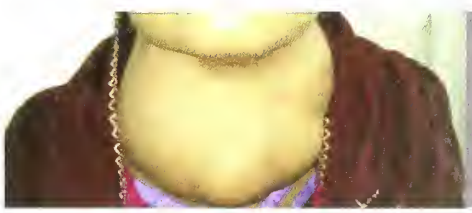

NEXT WEEK
The first of a two-part series looks at the causes of thyroid disorders

Acute sore throat

Which patients with a sore throat should be referred to their GP? Which ingredients of throat lozenges have been shown to be most effective? What are the Nice recommendations for the treatment of sore throat with antibiotics?

This article discusses the treatment of sore throats and includes information about causes and risk factors and when to refer a patient. It also describes the treatment and advice pharmacists can offer and the current rationale behind antibiotic prescribing.

- Read more about the symptoms and treatment of sore throat on the Patient UK website at http://tinyurl.com/sorethroat01.
- Find out more about the management of acute sore throat from the Clinical Knowledge Summaries website at http://tinyurl.com/sorethroat02.
- Revise your knowledge of the OTC products available for the treatment of sore throat from the C+D Guide to OTC Medicines. Review those stocked in your pharmacy, think about which ones you would recommend and make sure your counter staff are aware of your choices.

Are you now confident in your knowledge of the symptoms and treatment of acute sore throat? Could you advise patients about drug and non drug treatment and explain why antibiotics may not be necessary?

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Practical Approach

What are these itchy blisters?

At the Update Pharmacy, a man has asked at the medicines counter for antihistamine cream for itchy blisters on his hands and has been referred to pharmacist David Spencer.

In the consultation area David looks at the man's hands and sees a series of clear, deep-seated, tapioca-like vesicles on the sides of two or three fingers on both hands and one or two in each palm.

"You say these are very itchy," David says. "The surrounding skin looks a bit inflamed too. How long have you had this?"

"It started a couple of days ago. It began with a sort of burning feeling and then these blisters started appearing."

"Have you got any ideas about what might have caused it?"

"I thought at first it might be insect bites or something, but I haven't been out doing gardening or anything like that.

"My wife thought it might be scabies; she said a friend's kiddie had had it and it started with itching between the fingers."

"Have you had anything like this before?" David asks.

"No."

"This may sound like a strange question, but have you got anything like this on your feet?"

"No. Why, do you think it's a sort of athlete's foot?"

"No." David replies. "Do you suffer with asthma or eczema or have any allergies?"

"I do get hay fever in the early summer, but it's autumn now."

"Well," says David, "I think I know what it might be, but what to treat it with is a bit of a problem."

Questions

1. What does David think the man's condition is? How common is it? What are its main clinical features?
2. What is/are the causes?
3. Why does David say that treating it is a bit of a problem?

Answers

1. Pompholyx, a form of dermatitis. It accounts for around 5 per cent of cases of eczema of the hand. The usual age of those affected is 20 to 40, but it can affect teenagers and older people. There is a female preponderance of 2:1. The blisters occur mainly on the palms of the hands and sides of the fingers and hands, but the soles of the feet can also be involved. Blisters normally resolve spontaneously in three to four weeks. The condition may be acute, chronic or recurrent.
2. The aetiology is unknown, but there are a number of commonly identified aggravating factors, including emotional stress and allergens such as chromate, nickel and quinolones. Many other possible triggers have been suggested.
3. Pompholyx is difficult to treat effectively. Steroid creams are often prescribed to treat the itching. Use of OTC hydrocortisone or clobetasone cream is within the licensing conditions and could be used for up to one week. Systematic antihistamines could also be tried. A number of treatments have been used by dermatologists for severe or recurrent pompholyx, including the immunosupressants azathioprine and methotrexate, retinoids, the tumor necrosis factor-alpha inhibitor etanercept, and UV and PUVA therapies.

Main reference

Wollina U. Pompholyx: A Review of Clinical Features, Differential Diagnosis, and Management. Am J Clin Dermatol. 2010;11:305-314.

Got an idea for a Practical Approach scenario or would you like to write one? Email your suggestion to: **haveyoursay@chemistanddruggist.co.uk**

For more Practical Approach scenarios, go to **www.chemistanddruggist.co.uk/practicalapproach**

Emollients – the key to effective eczema management[1]

Emollient therapy protects and restores the skin's natural barrier function, which is deficient in people with eczema. This reduces both the frequency and severity of eczema flares.

Many patients with mild to moderate eczema can manage their condition with emollients alone, but emollients need to be used as frequently as possible to have maximum effect.[2] Commonly, however, people do not use sufficient emollient because they are not given appropriate advice on how to apply large enough quantities.[3]

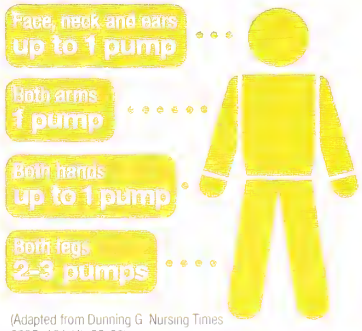
Pharmacists can facilitate adherence

Two important factors in facilitating adherence are an understanding of how treatment works and a recognition that the treatment is working.

Latest guidance from NICE recognises the importance of education in helping people with eczema to adhere to treatment.[1] Pharmacists are ideally placed to reiterate and build on education provided to patients by their GP or nurse.

Patients visiting the pharmacy can therefore usefully be reminded to apply their emollient:

- Every day, every three to four hours, even when skin is clear[4]
- In sufficient quantities
  - Skin should be shiny without residue
  - Far more emollient is required than a topical steroid [10:1 ratio][4]



(Adapted from Dunning G. Nursing Times 2005; 101 (4). 55-56)

Diprobase is tried and trusted

The Diprobase range of emollients has been soothing, healing and protecting sore skin[5] for more than 25 years. It's free from common sensitisers and irritants such as lanolin, parabens, perfume and sodium lauryl sulphate which can aggravate eczematous skin.[5]

Diprobase® Emollient

Tried. Trusted. Diprotected.

Diprobase Prescribing Information

Uses: Diprobase Cream and Ointment are emollients, with moisturising and protective properties, indicated for follow-up treatment with topical steroids or in spacing such treatments. They may also be used as diluents for topical steroids. Diprobase products are recommended for the symptomatic relief of red, inflamed, damaged, dry or chapped skin, the protection of raw skin areas and as a pre-bathing emollient for dry/eczematous skin to alleviate drying effects. **Dosage:** The cream or ointment should be thinly applied to cover the affected area completely, massaging gently and thoroughly into the skin. Frequency of application should be established by the physician. Generally, Diprobase Cream and Ointment can be used as often as required. **Contra-indications:** Hypersensitivity to any of the ingredients. **Side-effects:** Skin reactions including pruritus, rash, erythema, skin exfoliation, burning sensation, hypersensitivity, pain, dry skin and bullous dermatitis have been reported with product use. **Package Quantities:** Cream 50g tubes, 500g pump dispensers, Ointment 50g tubes. **Basic NHS Costs:** Cream £1.28 (50g), £6.32 (500g), Ointment £1.28 (50g). **Legal Category:** GSL. **Marketing Authorisation Numbers:** Cream 0201/0076; Ointment 0201/0075. **Marketing Authorisation Holder:** Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts, AL7 1TW. **Date of Revision:** August 2010.

Diprobath Prescribing Information

Diprobath is a liquid preparation for external use as a bath additive. It contains Light Liquid Paraffin 46% w/w and Isopropyl Myristate 39% w/w. **Uses:** As a bathing emollient for the treatment of dry skin conditions and hyperkeratoses, including dermatitis and eczema. **Dosage:** 25ml (2.5 capfuls) to an adult size bath (approx. 100 litres) or 10ml (1 capful) for children's baths (approx. 25-30 litres). For particularly dry skin, these quantities may be doubled. The frequency and duration of bathing will depend on the severity of the condition, but generally 2 to 3 baths should be taken weekly. **Contra-indications, Warnings:** Hypersensitivity to the ingredients contra-indicates use. Patients should be advised to use care when entering or leaving the bath which may be more slippery than usual. **Package Quantities:** 500ml bottle. **Basic NHS Costs:** £6.74. **Legal Category:** P. **Marketing Authorisation Number:** 0201/0174. **Marketing Authorisation Holder:** Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts, AL7 1TW, UK. **Date of Revision:** September 2010.

Please refer to the full SPC text before prescribing this product.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Schering-Plough Drug Safety Department on +44(0)1707 363773.

References: 1. National Collaborating Centre for Women's and Children's Health (2007) Atopic eczema in children. Management of atopic eczema in children from birth up to 12 years old (NICE Full guidance). London, December 2007. www.nice.org.uk 2. Cork, MJ (1997) The Importance of Skin Barrier Function. J Dermatol Treat, 8, S7-S13. 3. Clark, C & Hoare, C (2001) Making the most of emollients. Pharm J, 226, 227-229. 4. PCDSBAD (February 2006) Guidelines for the management of atopic eczema. http://www.eGuidelines.co.uk (Accessed October 2010). 5. Diprobase SPCs (Accessed October 2010) www.emc.medicines.org.uk

Code: DIP10 GB 16960 J. **Date of preparation:** October 2010. **Date of expiry:** October 2012

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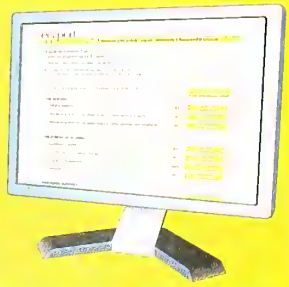


FREE educational initiative

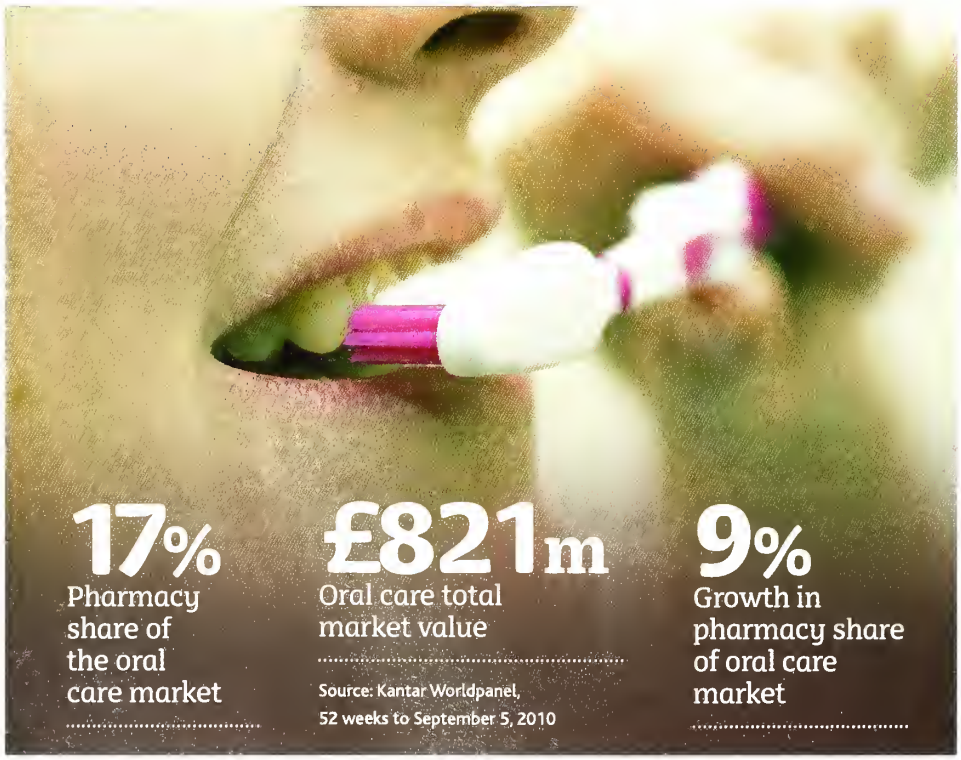
At MSD, we're keen to help pharmacists support people with eczema, which is why we've developed Eczpert, a FREE online education programme for pharmacists.

Eczpert provides comprehensive information about eczema, its treatment – including benefits of the MUR for eczema patients, providing support to patients and reducing the impact of eczema; and giving you 12 hours of CPP accredited Continuing Professional Development (CPD).

CATEGORY FOCUS

Oral care

Oral care is bucking the OTC trend, with pharmacy outperforming grocery in share growth. **Chris Chapman** reveals how to make the most of this £820m category



Oral health is considered a top priority by the government. Last month pharmacy minister Earl Howe launched Smile4Life, a programme aiming to boost oral health among pre-school children in Lancashire. Speaking at the programme's launch he said that, despite improvements, "there is more that can and should be done" to tackle inequalities in oral health.

"Tooth decay in children is a serious problem," Earl Howe said. "It can cause a great deal of pain and discomfort, and treating it is very costly for the NHS. Focusing on prevention is not only better for the children, but is also a better use of resources."

Naturally, this is where pharmacies come in – demonstrated by the fact that oral care sales are bucking the trend of other OTC categories. Pharmacy sales in the category, for both adults and children, grew by 9 per cent in the past year, outperforming other retailers in a market that saw an overall growth of just 5 per cent.

In terms of sales, Boots and Superdrug both have a significant stake in the £820 million market, holding their own against supermarkets and their own-label oral health brands proving popular with customers.

But it's not just the multiples that have seen sales rise, says Numark retail excellence manager Emma Charlesworth: "The oral care category continues to grow within independent pharmacy. It now accounts for 6.4 per cent of total OTC."

The reason, Ms Charlesworth says, is that patients need an accessible expert when it comes to looking after their oral health.

"It's easy to think that oral care is better placed in dentistry," she says, "but pharmacy is one of the first places people will come for advice."

Boots pharmacist Angela Chalmers agrees. "The most common oral health problem I see is mouth ulcers, both recurrent and one-off. It is important to discuss good oral hygiene, provide a suitable painkilling/healing gel and remind them to see a dentist or GP if it takes longer than a week to heal," she advises.

Recurrent mouth ulcers can be linked to underlying causes and should be referred

Market Insight

Oral care is made up of brushes, paste, mouthwash, dentifrice and dental floss. The market value grew by 5 per cent to £821 million over the past year, with pharmacy outperforming with a 9 per cent growth.

Growth in oral care has been consistently driven by shoppers spending more than the previous year. The average shopper now spends £32.50 on oral care per year, up from £30.83 in 2009. Buying more expensive products and promotions encouraging the shopper to put more in their basket have both helped to push this average spend up.

'Sensitive' products have been important to growth in the past year, with shoppers willing to pay the higher prices that are associated with these products. Colgate's launch of Sensitive Pro Relief, Sensodyne's continued growth, and Listerine Total Care Sensitive are all examples of this part of the market performing strongly. In the future, products that offer benefits that the consumer believes are worth paying for will continue to be successful and drive growth.

Of the major grocers, only Morrisons has grown faster than the market; all the others have lost share. Boots has experienced the largest share gain this year in oral care, bucking the trend of many other high street retailers and driving growth for pharmacy. Electric toothbrushes continue to be important to sales in Boots. The range is available and shoppers have demonstrated that if they want to buy a more expensive product they have a preference for purchasing in a specialist retailer.

Higher average spend also drove growth – specifically in pharmacy, with the average pharmacy shopper spending £20.50 per year on oral care, up from £18.77 in 2009.

As with previous years, though, pharmacy has lost shoppers this year, which has negatively impacted on growth. Thirty five per cent of the population bought an oral care product in pharmacy in 2010, down from 39 per cent in 2008 – a loss of almost one million shoppers.

Paste continues to be an area of under-trade for pharmacy, making up just 16 per cent of sales, compared to 37 per cent in the overall market (see How the subcategories compare, p24).

Market changes 2009-10: Oral care

Total market value
£821.4 million ▲ 5%

Pharmacy
£140.3 million ▲ 9%

Source: Kantar Worldpanel, 52 weeks to September 5, 2010. Data and analysis provided for C+D by Kantar Worldpanel (strategic insight director Tim Nancholas)

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- ✓ *Forms a* ***fast-acting protective barrier*** *over the ulcer which lasts for up to* ***4 hours***
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- ✓ ***Aids healing*** *of the mouth ulcer*
- ✓ *A unique precision applicator* ***to target the ulcer easily***

bonjela *Complete mouth ulcer care*

Always read the label for use.

5 tips for boosting toothbrush sales

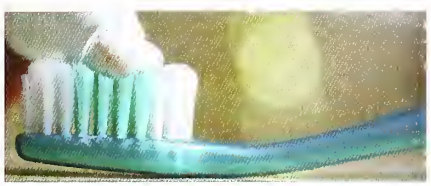
Rob Jackson, UK pharmacy shopper-based design manager for P&G PharmacyCare, recommends the following:

1. Get the subcategory space right, and allocate the right brand space, focusing on brand leaders. The leading brand for both manual and electric tooth brushes is Oral-B.
2. Lay out the brushes by brand, but limit the number of brands to three or four – less is more.
3. Make sure you offer a range of prices, and have a dedicated children's section.
4. The market for powered brushes is growing. Stock an entry range of one or two products at around £30. P&G runs promotions that take the retail price to around £20.
5. Christmas is a key trading period for power brushes – so allocate space accordingly.

How the subcategories compare – total market

Source: Kantar Worldpanel, 52 weeks to September 5, 2010

Best-selling oral care brands



Total market	Pharmacy
1 Colgate	1 Oral-B
2 Oral-B	2 Boots
3 Aquafresh	3 Colgate
4 Listerine	4 Sonicare
5 Sensodyne	5 Sensodyne
6 Plax	6 Listerine
7 Corsodyl	7 Corsodyl
8 Tesco own label	8 Aquafresh
9 Dentyl	9 Dentyl
10 Macleans	10 Reach

Source: Kantar Worldpanel, 52 weeks to September 5, 2010

to a GP. Patients who are giving up smoking should also be warned that blood flow to gums increases after quitting, and may cause an increase in mouth ulcers.

Pharmacists can also help patients who grind their teeth, Ms Chalmers says: "Grinding teeth can lead to tooth or jaw pain and headaches. [Patients] can try a gum guard and relaxation techniques before bed, to get out of the vicious cycle of grinding."

Gum disease is another key area for advice. "Receding gums should be assessed by a dentist," says Ms Chalmers, "but in the meantime, pharmacists can recommend soft-bristled toothbrushes, less-vigorous flossing and alcohol-free mouthwashes."

And it's worth remembering that many of a pharmacy's patients will benefit from oral health products, presenting the possibility of linked sales. For example, drug misusers often have poor dental health, in part due to the high sugar content of methadone, and may benefit from sugar-free chewing gum. Patients with long-term conditions such as diabetes or who are immunocompromised are also at increased risk of gum disease. Conditions such as oral thrush or dry mouth can be iatrogenic, and may require advice from a pharmacist.

There is no doubt that oral care will continue to be a key category for pharmacy in the future. The government's focus on oral health and pharmacy's reputation for advice on the high street means that footfall should continue to increase as patients seek expert advice on their oral care, meaning the category will only go from strength to strength.

Brand Watch: Sensodyne

Sensodyne lies fifth in the market for both pharmacy-only and total oral care sales, showing this toothpaste for sensitive teeth has a strong position in the market.

Earlier this year the brand expanded, with manufacturer GlaxoSmithKline (GSK) Consumer Healthcare launching Sensodyne Rapid Relief – which can provide relief in 60 seconds when applied directly with a fingertip for one minute.

The new product aims to encourage new users into the market, as 75 per cent of patients have never used a desensitising toothpaste, or use one infrequently. During the summer, the launch was supported by a £6 million marketing campaign, including a new TV ad that built on previous testimonial campaigns.

Sensodyne Rapid Relief, with strontium acetate and sodium fluoride, is available in 45ml and 15ml tubes and 100ml pump, retailing at £2.45, £3.65 and £4.29 respectively.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on oral health

REFLECT	Do my patients get the most out of oral care products?
PLAN	Review my and my staff's knowledge and sales protocols.
ACT	Read this article, revise common oral health conditions – such as mouth ulcers, oral thrush and dry mouth – review available products and arrange training as necessary.
EVALUATE	Do my patients get better oral health advice?

Branded v own label – total market

Branded
£741m
+6%

Own label
£81m
-1%

Case study

Numark
Emma Charlesworth

The support group's retail excellence manager says Numark members have been helping to improve their patients' oral health through direct collaboration with dental colleagues. "Some Numark members are working with their dentist colleagues through local pharmaceutical committee/local dental committee collaboration," Ms Charlesworth says.

"They signpost each other's services and run joint health promotions – for instance, for National Smile Month.

"Although dentists can give expert advice on teeth and oral hygiene, pharmacy is in a prime position when dealing with different conditions that affect the mouth – and not everyone has a six-month check-up at the dentist."

To boost sales, Numark also advises the use of 'beacon brands', such as Colgate, to help customers find the section. Numark members are also advised to split toothbrushes and toothpastes by denture care, as customers buying dentures tend to be older – meaning the products need to be accessible. Dentures are also a destination category for pharmacies, and should be in a prominent position, Numark says.

Children's oral care products should be grouped together, and at their eye level to help drive sales through customer interaction, Ms Charlesworth advises. This also gives pharmacists a great opportunity to offer advice on keeping children's teeth and gums healthy.

Product Watch

Bioténe

Manufacturer: GSK Consumer Healthcare
Classification: GSL
For: The relief of dry mouth
Active ingredients: Oralbalance: liquid formulation; dry mouth toothpaste: enzyme system, fluoride, calcium, xylitol; mouthwash: enzymes, xylitol, calcium.
What's new? The Bioténe range was given a new design earlier this year. Bioténe Moisturising Mouthwash is now available in a 500ml bottle, replacing the 250ml bottle and bringing it into line with other daily mouthwashes.
www.mypharmassist.co.uk
Tel: 0845 762 6637

Format/pack size: 500ml (Moisturising Mouthwash)
Pip code: 355-6750 (for Pip codes for other products in the range, see C+D Monthly Price List or www.cddata.co.uk)
RRP: £9.99 (range from £6.50)

Bonjela Complete Plus

Manufacturer: Reckitt Benckiser
Classification: Medical device
For: Mouth ulcer relief and treatment
Active ingredients: None licensed
What's new? Complete Plus was added to the Bonjela range in March this year. It forms a long-lasting protective barrier over the mouth ulcer to aid healing.
Tel: 0500 455456

Format/pack size: 10ml
Pip code: 353-6588
RRP: £7.99

Poligrip Denture Cleansing Tablets

Manufacturer: GSK Consumer Healthcare
Classification: GSL
For: Cleaning dentures
Active ingredients: Sodium bicarbonate, citric acid. For a full list see www.gskdirect.co.uk
What's new? The two cleansing tablets, 3 Min Ultra and Total Care, were launched in June. Poligrip 3 Min Ultra Denture Cleansing Tablets deep clean in three minutes, while Poligrip Total Care Denture Cleansing Tablets are antibacterial. Both products are non-abrasive and do not scratch denture surfaces.
www.mypharmassist.co.uk
Tel: 0845 762 6637

Format/pack size: 33 tablets
Pip code: 355-3849 (3 Min Ultra); 355-3831 (Total Care)
RRP: £1.29

Dentogen Clove Oil

Manufacturer: Anglian Pharma
Classification: GSL
For: Temporary relief of toothache due to dental cavity
Active ingredients: Clove oil 20 per cent
USP: Clove oil is a natural local anaesthetic and antibacterial agent. Dentogen is a sugar-free formula.
Tel: 0115 841 9795
Email: admin@powermeduk.co.uk

Format/pack size: 10g
Pip code: 000-6353
RRP: £2.55

Iglü

Manufacturer: DDD
Classification: Gel P; rapid relief gel GSL
For: Mouth ulcer relief and treatment
Active ingredients: Lidocaine hydrochloride, aminoacridine hydrochloride
What's new? Iglü rapid relief gel was launched in September 2009 as a GSL range extension. Both formats form a long-lasting protective barrier over the mouth ulcer to aid healing.
www.dddgroup.co.uk

Format/pack size: 8g tube
Pip code: 331-3319 (gel); 346-6760 (rapid relief gel)
RRP: £5.99

Oral-B ProfessionalCare 5000 power brush

Manufacturer: Procter & Gamble
For: Cleaning teeth
USP: The ProfessionalCare 5000 naturally whitens teeth in just two weeks by removing surface stains, the manufacturer claims. It is the rechargeable toothbrush endorsed by the British Dental Health Foundation.
www.oral-b.com/uk

Pip code: 346-8279
RRP: £163.47

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on 01922 659262 (office hours) Agency contact by email only

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or email angie.williams1@sky.com

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CAREERS

Your redundancy rights

Lawyers **Adam Rice** and **Anna West** answer eight frequently asked questions

Job security remains a key concern for pharmacists, the C+D Salary Survey indicated earlier this year. And, according to the Chartered Institute of Personnel and Development, redundancies remain on the cards for many into 2011. Here's what you need to know if the worst happens.

I suspect my company wants to make me redundant and then replace me in a few months. Can they do this?

If the company intends to replace you, then it means you are not really redundant. Labelling a dismissal as a redundancy when in reality it is for another reason will make your dismissal unfair.

If you have been unfairly dismissed you could claim compensation for your losses up to a maximum of around £70,000.

I have been selected for redundancy and have applied for an internal vacancy, but the company seems to prefer to recruit externally. Can they do this?

If the role is a suitable alternative for you, ie a role at a similar level that you are capable of doing, then the opportunity should be offered to you ahead of an external candidate. Failure to do so is likely to lead to a successful unfair dismissal claim.

They should only seek an external candidate if you, or any of your redundant colleagues, are not competent to fill the role.

Can the company take my attendance into account when deciding who should be made redundant?

If you have had periods of sickness absence due to a disability, you could have a claim for disability discrimination if these absences are taken into account.

In this context, a disability is a long-term illness (ie lasting or expected to last for at least a year) which significantly impacts on your day-to-day life.

Similarly, if you have been absent for reasons relating to pregnancy or childcare, you may have a claim for sex discrimination if these absences are taken into account.

Can the company use length of service when deciding who will be made redundant?

Using length of service (eg 'last in, first out') is likely to amount to indirect age discrimination as it favours longer-serving employees, who are usually older.

However, it can be lawful for the company if they can justify this by showing that it has a legitimate purpose, such as rewarding loyalty or retaining business-specific experience, and there is no less discriminatory way of achieving that aim.

Length of service is more likely to be lawful when used as one of a number of criteria, or even as a 'tie-breaker', rather than as the sole criterion.

The company went through a scoring process to decide who should be made redundant. Can I ask the company to show me my teammates' scores?

You are entitled to see your own scores as part of a fair redundancy process. While you are not strictly entitled to see the scores of your colleagues, a failure to hand them over could convert the redundancy into an unfair dismissal.

However, this needs to be done anonymously to protect the privacy of other staff. The company might be justified in withholding the scores if they think the identity of the other employees would still be obvious to you.

I have been with the company just short of two years and am being made redundant. Is it true that the company doesn't have to pay me anything?

Employees are only entitled to a statutory redundancy payment if they have two years continuous service. If you have worked for the company in another branch or part of a group, this will usually count.

While you might not be entitled to a statutory payment, you might be entitled to an enhanced redundancy payment under your employment contract or your company's redundancy policy, so it is worth checking this.

I have just told my manager that I am pregnant. Does this mean that I cannot be included in a redundancy process?

Sadly, no – you can still be selected for redundancy, as long as the reason for your selection is not related to your pregnancy, future maternity leave or childcare responsibilities.

If it is, then this will amount to sex discrimination – for which you could claim unlimited compensation for your losses (based on the time it takes to find a new job) and also compensation for injury to feelings of up to £25,000.

Will my redundancy payment be taxed?

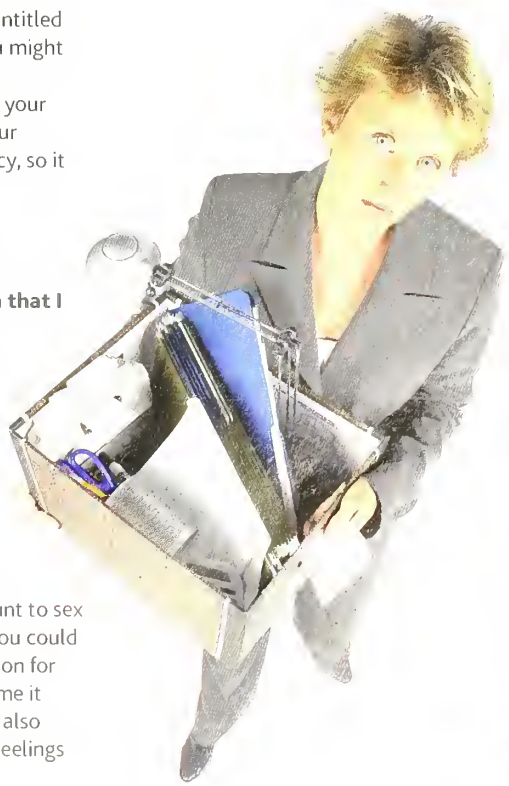
Payments of up to £30,000 made genuinely on account of redundancy will be free of tax; and the entire amount, even if it is above £30,000, will be free of national insurance contributions.

It is common, however, for the overall redundancy package to include a component for payment in lieu of notice (PILON), which would be taxed differently.

A PILON will usually be subject to PAYE tax and national insurance contributions in the usual way. This would be the case if there were a clause in an employment contract that allowed the company to make such a payment instead of giving notice.

Even if the PILON is taxable, any separate amount that is paid for redundancy, including any statutory or enhanced redundancy pay, should come under the £30,000 tax-favourable regime.

Adam Rice and Anna West are employment law specialists at solicitors Travers Smith LLP



CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on redundancy

REFLECT	Do I understand my rights if my company is making redundancies?
PLAN	Revisit relevant sections of my employment contract.
ACT	Read this article and consider which aspects of the law and my employment contract I need to revisit.
EVALUATE	Do I better understand my rights if my company makes redundancies?

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COURSES

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28th November 2010 from 9.00am to 4.00pm.

Venue: St Heliers Hospital, Post Graduate Medical Centre, Wrythe Lane, Carshalton, Surrey SM51AA.
For further details please contact Course Director: Mitta Bathia
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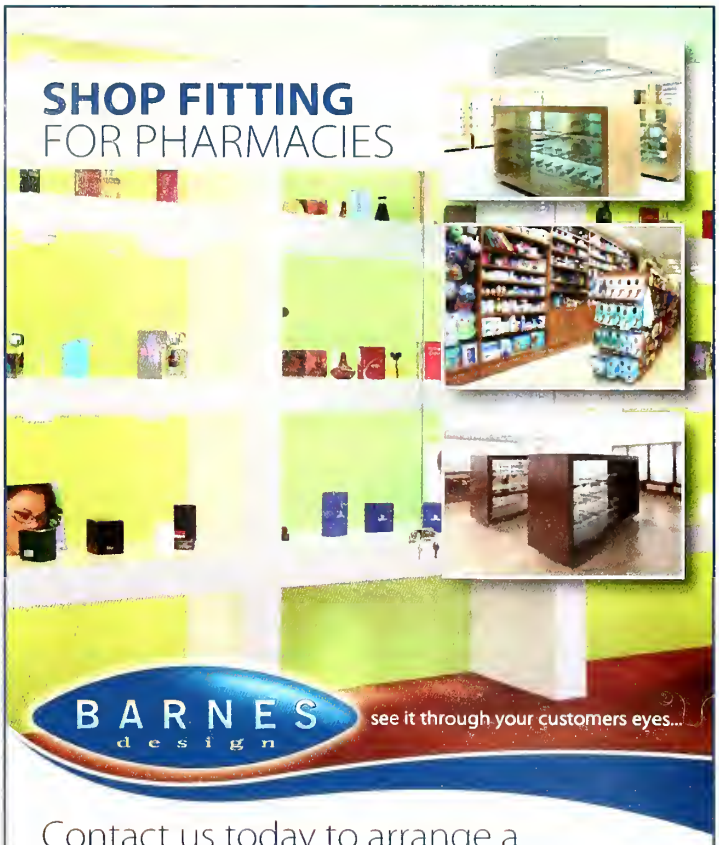
SHOP FITTING FOR PHARMACIES



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Postscript

C+D Christmas Competition 2010

Would you like to get your hands on a bottle of champagne this Christmas? If so, show us how you've been decorating your pharmacy for the festive season.

We want pictures of your Christmas-themed pharmacy and not only will you win a bottle of bubbly in time for Christmas, you will also be featured in C+D's Christmas issue.

Send in images of your shop fronts, displays or festive counters and the C+D team will decide which pharmacy has the best Christmas decorations this year.

To get your hands on the prize, please send a high resolution image to postscript@chemistanddruggist.co.uk by December 10, or Christmas Competition 2010, C+D, Ludgate House, 245 Blackfriars Road, London, SE1 9UY.

A social tweet

The Isle of Wight pill pilot dominated Twitter last week. You can join the debate at www.twitter.com/chemistdruggist

@CandDChris: Strongest statement yet from RPS (pharmacy's professional body) that homeopathy has no evidence: http://tinyurl.com/338p2zq.

@jonathanmason: Whatever the media flak, the IoW service offers a convenient route into long-term contraception so should be a good thing.

@CandDHannah: In case you missed it, here's the issues raised about how media covers contraception/pharmacy pilots: http://bit.ly/7T90SG

C+D reader of the week

Meet independent pharmacist Graham Jones, who couldn't live without his Blackberry

What's your favourite soap opera? I don't watch soaps and I can't think of any equivalent.

What is your ideal holiday destination? I went to the pharmacy business awards dinner where my wife won a raffle for tickets to Dubai, so it will probably be there.

What makes a good pharmacist?
Someone who is empathetic, but also has a good clinical grounding so they can make good judgements.

What is your favourite book?
I rarely read novels, but a friend gave me a German novel called The Reader by Bernard Schlink.

Who would you invite to your ideal dinner party? Stephen Fry seems like he would be a good guest. As I am heavily involved in politics, I would have to have Margaret Thatcher – I think she would be an interesting mix. If I can have people who are no longer alive I would have Churchill and Gandhi as well.

What pharmacy services would you like to see? I would like to see a cardiovascular service rolled out on a national level, but we appear to be struggling to achieve that.

What object could you not live without?
Unfortunately, I have a Blackberry and it's amazing how quickly you let it take over your life.

What question should we ask our next reader of the week? Should we change the clocks in the spring and autumn in this country?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

@The web hunter

A certain fruit-like computer and mobile device manufacturer is cornering the market with its innovative products and catchy ads and straplines. And they seem to think of everything, according to their slogan: "We've got an app for that."

It doesn't stop with Apple either. Google's Android platform is the fastest-growing mobile platform and also offers a range of apps. But is there truly an app for everything?

As you may have noticed, Chemist+Druggist has started offering its CliniCal app. Its premise is simple – 132 formulas and scoring tools, featuring everything from BMI and cardiac risk scores to creatinine clearance and dosing regimen calculations. But what else is out there?

Trawling through Apple's App Store, I came across a couple of reasonably titled apps. Among them is (C+D's parent company) UBM Medica's US division's PhotoClinic, which, much like C+D's picture quizzes, offers photos of conditions, their diagnosis and treatment options. It is very US-centric and predominantly aimed at GPs, but is worth a look.

Another I found was simply called iPharmacy. Again a US app, this one allows a pharmacist to look up a drug and offers a BNF-style list varying from usage, dosage, adverse reaction and so on, as well as its national drug code.

But from there, the offerings for pharmacy get quite poor. Sure there are plenty for patients looking for their nearest pharmacy, but for the health professional there is a dearth. And some (which I won't name here on libel grounds) offer a poor range of information on a limited selection of drugs; and herein lies the problem.

Can an app or any other health tool truly be offered as anything other than either an entertaining distraction of gross pictures or a specific list of products? Is it possible to make an app that can be used as a true diagnostic tool? Or are apps just another weapon in the arsenal of the healthcare professional?

Answers on a postcard please. And if you have any great ideas for useful tools or apps that could aid pharmacy, the Webhunter would like to know.
Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com

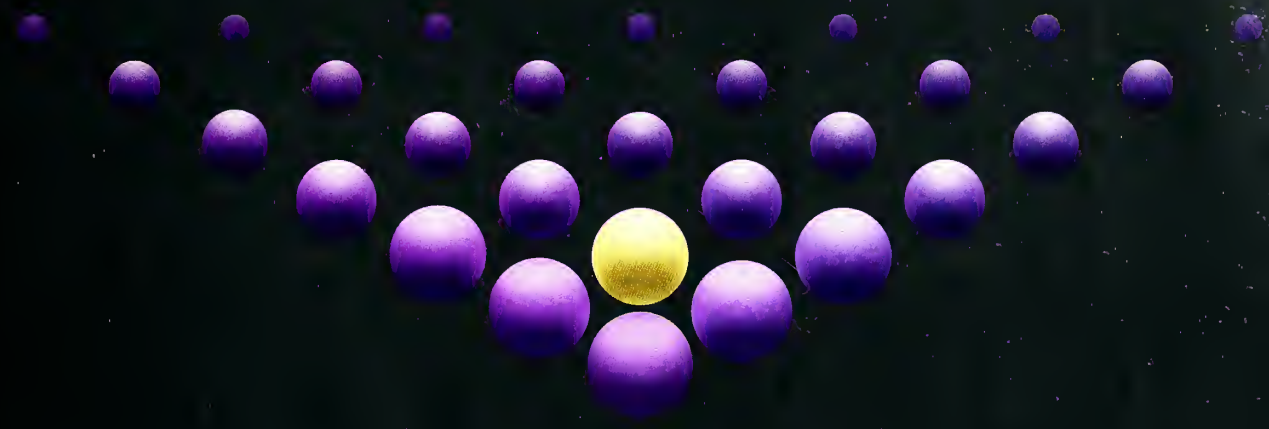
Last week's top stories on C+D's website

1. Clinical quiz: An unusual thumb nail

2. RPS condemns homeopathic products

3. Practical approach: What's causing this blackened tongue?

C+D AWARDS 2011



THE SEARCH IS ON

Look out for the 2011 categories and how to enter in next week's issue

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